

# *Evaluation*



# *Report*

OFFICE OF THE INSPECTOR GENERAL

**EVALUATION REPORT ON THE  
MANAGEMENT OF COMBAT STRESS CONTROL  
IN THE DEPARTMENT OF DEFENSE**

Report No. 96-079

February 29, 1996

DTIC QUALITY INSPECTED 4

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**DEPARTMENT OF DEFENSE**

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## **Acronyms**

ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BICEPS	Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity
CINC	Commanders in Chief
IMPRESS	Immediacy, Military milieu, Proximity, Rest and replenishment, Expectancy, Simplicity, Supervised in a military role
LPXMED	Logistics Processing External - Medical
MEPES	Medical Planning Execution System
MPM	Medical Planning Module
MRSP 2001	Medical Readiness Strategic Plan 2001
NCO	Noncommissioned Officer
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
PIE	Proximity, Immediacy, Expectancy
SPRINT	Special Psychiatric Rapid Intervention Team



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February 29, 1996

**MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS**  
**ASSISTANT SECRETARY OF DEFENSE**  
**(HEALTH AFFAIRS)**  
**DIRECTOR, JOINT STAFF**

**SUBJECT: Evaluation Report on the Management of Combat Stress Control**  
**in the Department of Defense (Report No. 96-079)**

We are providing this final report on our evaluation of the management of combat stress control for your review and comment. Management comments on a draft of this report were considered in preparing the final report and were sufficiently responsive so that no further comments are required at this time.

We appreciate the courtesies extended to our evaluators. If you have any questions about this evaluation, please contact Mr. Philip Velthuis, Program Director, at (703) 604-8746 (DSN 664-8746) or Ms. Betsy Brilliant, Evaluation Director, at (703) 604-8745 (DSN 664-8745). The distribution of this report is listed in Appendix C. The evaluation team members are listed inside the back cover.

Robert J. Lieberman  
Assistant Inspector General  
for Auditing

## Office of the Inspector General, DoD

Report No. 96-079  
(Project No. 6LH-9012)

February 29, 1996

### Management of Combat Stress Control in the Department of Defense

#### Executive Summary

**Introduction.** Controlling combat stress is a significant factor in sustaining a healthy deployed fighting force. Military leaders and health care professionals need to understand the importance of controlling combat stress. Those individuals need adequate training in preventing, identifying, and treating combat stress casualties. The ultimate goal is to make the combat stress casualty "fit for duty" and return that individual to the field. Because combat stress can significantly contribute to battle injury losses, it is important to understand its causes and to develop and implement effective and efficient combat stress prevention, identification, and treatment programs.

**Purpose.** The purpose of the evaluation was to assess the structural processes of planning, implementing, and training, related to combat stress control programs within DoD, to determine whether those structural processes support management of combat stress through prevention of combat stress, identification of combat stress casualties, and treatment of those casualties.

**Evaluation Results.** Combat stress control has been identified as a medical threat and is addressed in the medical planning resource systems. However, no central point of contact exists in DoD for handling combat stress control issues; and insufficient joint doctrine exists addressing combat stress control. Also, some Service programs need improvement, and training associated with combat stress control needs to be enhanced. Our specific findings follow.

- o The Joint Staff, the Assistant Secretary of Defense (Health Affairs), and the Military Departments have incorporated combat stress into their medical planning. First, Joint Chiefs of Staff Instruction 3110.03, "Logistics Supplement to the Joint Strategic Capabilities Plan," requires that "battle fatigue" be considered as a medical planning condition. Second, the new medical planning software includes "battle fatigue" as a population-at-risk casualty planning factor. Third, the Assistant Secretary of Defense (Health Affairs) Medical Readiness Strategic Plan 2001 includes action plans that address the need to improve medical readiness planning and tie medical readiness planning to the patient condition codes that include "stress reactions." Successful implementation of that strategic plan requires aggressive oversight by the Assistant Secretary of Defense (Health Affairs).

- o Various DoD Components are involved in implementing policy or programs associated with combat stress management, including the Office of the Secretary of Defense, the Joint Staff, and the Services. While individuals in the Office of the Secretary and in the Military Departments are working combat stress control issues, no central point of contact responsible for combat stress management issues exists within the Office of the Secretary of Defense. At the Joint Staff level, there is insufficient joint doctrine addressing combat stress prevention, identification, and treatment to support combat stress management in ever-increasing joint operations.

o At the Service level, the combat stress control programs offered by the Navy and the Air Force are inadequate to support their members. Military training in combat stress control and management is not being adequately provided by all Services to all ranks and levels of responsibility. That training should be part of a total training program for each member depending on the member's branch, rank, and level of responsibility. The Army program includes combat stress management training throughout the member's career. The Marine Corps program is less aggressive and does not provide training at later stages in the member's career. The Air Force and the Navy need to expand their programs to include training in combat stress management at all appropriate levels. In addition, joint Service training is not included in any of the programs, which could impact the effectiveness of the fighting force in the ever-increasing joint operations.

**Potential Benefits of Evaluation.** The DoD has identified combat stress as a medical threat and has incorporated combat stress casualty planning into its operational planning. Implementation of our recommendations should result in a systematic management approach that leads in turn to improved combat stress management, healthier service members, increased unit cohesion, and a more effective fighting force.

**Summary of Recommendations.** We recommend that the Assistant Secretary of Defense (Health Affairs) ensure that the action plans in the Medical Readiness Strategic Plan 2001 addressing medical planning be monitored for implementation. We also recommend that the Assistant Secretary of Defense (Health Affairs) assume functional responsibility for combat stress control management and issue policy requiring each Military Department to develop a comprehensive combat stress control program. We further recommend that the Joint Staff incorporate combat stress management into joint doctrine. Finally, we recommend that the Services ensure appropriate training concerning the management of combat stress control is provided to their service members.

**Management Comments.** The Army, the Navy, the Air Force, the Assistant Secretary of Defense (Health Affairs), and the Director, Joint Staff, concurred with the recommendations. The Army suggested that we expand the last recommendation to have the Services explore joint Service training.

**Audit Response.** Comments from the Army, the Assistant Secretary of Defense (Health Affairs), and the Director, Joint Staff, were responsive. The Navy and the Air Force comments were partially responsive. Based on the comments from the Army, we expanded the last recommendation to explore joint Service training. We will pursue the details of training enhancements in future followup inquiries and therefore no further comments are required from management at this time.

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## PART I - INTRODUCTION

According to the field manuals on combat stress control published by the Army and Marine Corps, combat stress is a process, within an individual, of reacting to and preparing to deal with physical or mental stressors occurring during combat-related duties. Stressors are those events or situations that require a non-routine behavior change or pose a threat to the individual. Stressors may be due to enemy action or other sources, such as environment, mission demand, or the member's unit, leaders, or family. Combat stress can have both positive and negative effects. We will further define combat stress and combat stressors in the Background section of this report.

Combat stress control is a critical component of total military readiness. To be effective in combat, service members must sustain their mental as well as physical health. Controlling combat stress is a significant factor in sustaining a healthy deployed fighting force. Military leaders and health care professionals need to understand the importance of controlling combat stress. Those individuals need adequate training in preventing, identifying, and treating combat stress casualties. The ultimate goal is to make the combat stress casualty "fit for duty" and return that individual to the field. Because combat stress can significantly contribute to battle injury losses, it is important to understand its causes and to develop and implement effective and efficient combat stress prevention, identification, and treatment programs. In addition, because treatment of combat stress casualties is likely to cross Service lines in joint operations, both Service and joint practices are necessary for a successful combat stress management program.

### PURPOSE

The purpose of our evaluation was to assess the structural processes of planning, implementing, and training, related to combat stress control programs within DoD, to determine whether those structural processes support management of combat stress through prevention of combat stress, identification of combat stress casualties, and treatment of those casualties.

### OBJECTIVES

The evaluation objectives were to:

- survey and review the structural planning process for combat stress control programs within DoD to determine levels of consideration by the Office of the Secretary of Defense, the Joint Staff, and the Military Departments.
- evaluate the structural implementation process of combat stress control programs within DoD, especially within the Services, to determine the completeness of those programs, that is, addressing combat stress casualty prevention; identification; and treatment; and any requirements for joint operations.

- evaluate the structural training process of combat stress control programs within DoD that support prevention, identification, and treatment of combat stress casualties.

## SCOPE AND LIMITATIONS

### Scope

The evaluation covered operational and proposed combat stress control structural processes and programs within the Office of the Secretary of Defense, the Joint Staff, and the Services. We reviewed the processes and programs from predeployment through redeployment. Predeployment begins when a unit is notified that troops will be deployed to a designated area of operations. Redeployment occurs when the service members return to their home station.

### Limitations

We limited our survey and review to existing and proposed combat stress control structural processes and programs, and the completeness of those processes and programs from predeployment through redeployment. The completeness of supplemental stress control programs (for example, suicide prevention or family advocacy programs) applicable during nondeployment periods was not evaluated. In addition, we did not evaluate the effectiveness of the outcomes of combat stress control programs.

## METHODOLOGY

### Data Collection

Our evaluation was accomplished in two phases, data collection and a comprehensive comparative data analysis.

#### *Literature Search*

To gain a thorough understanding of combat stress and combat stress control programs operational within DoD, the civilian community, and other countries, we conducted a comprehensive review of current literature. A complete list of journal articles, books, reports, and documents reviewed is in Appendix A.

From that information, we gained an understanding of the magnitude of combat stress during previous wars and operations other than war. We also identified the key elements of a comprehensive combat stress control program--prevention, identification, and treatment. In addition, we researched the existence and role of supplemental stress control programs. We used the information collected to derive our research questions for the site visits and interviews.

#### *Site Visits and Interviews*

We conducted interviews with key DoD staff involved in combat stress control programs and training. Specifically, we met with personnel in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]), the Joint Staff, the Services, a unified command, and selected Service units and support elements. We also met with personnel at selected civilian

organizations involved in crisis and stress management. To complement the international perspective of our literature review, we met with a representative from the British Embassy involved in combat stress control for the United Kingdom. A complete list of the organizations and offices visited or contacted is in Appendix B.

### **Comparative Data Analysis**

After completion of the literature search, site visits, and interviews, we performed a comparative data analysis. That analysis focused on the structural processes--planning, implementation, and training. For the first objective, we focused on the existence of planning documentation within DoD relating to combat stress control. We did not evaluate the outcomes produced by those planning documents. For the second objective, we evaluated the existence and completeness of the Services' combat stress control programs, specifically as they related to the three key elements of a comprehensive program. For the third objective, our analysis was based on Service-level training courses within DoD that addressed combat stress. We did not examine courses at the base or unit level nor did we evaluate the quality of the individual training programs or measure the outcomes of any training program.

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## PART II - BACKGROUND

Combat stress is not new. It is an inevitable consequence of military conflicts and operations. Documentation concerning combat stress dates back to the Civil War. Incidences of combat stress vary with, among other things, the location and intensity of the conflict, the mission, the cohesion of the military unit, and individuals involved. The goal of prevention of combat stress is controlling the stress level. Controlling combat stress is a critical factor in the success or failure of human conflicts. Successfully controlling combat stress will ultimately prevent psychiatric casualties. Preventing those casualties is the responsibility of every service member, from the junior enlisted member to the senior officer.

In this section we will provide a historical overview of combat stress in military conflicts and operations, a general overview of combat stress and the major elements of a comprehensive combat stress control program, and a brief overview of supplemental stress control programs that support combat stress control programs.

### HISTORICAL OVERVIEW

While combat stress reactions have been acknowledged and treated by the military since the Civil War; until recently the lessons learned during previous conflicts were not always applied in subsequent conflicts. The historical overview that follows demonstrates the magnitude of the failure to learn from the lessons of the past when handling stress-related casualties during military conflicts.

#### Prior to World War I

There is evidence of emotional and physical reactions to the stress of combat during the Civil War. During the Civil War, war-related stress was known as nostalgia, or homesickness. Sometimes it was referred to as a weakness of the heart. From the period following the Civil War to before World War I, very little information is available concerning combat-related stress casualties. Specifically, little information is available regarding combat stress during the Indian Wars, the Spanish-American War, or the Philippine Insurrection, none of which approached the battle intensity of the Civil War.

#### World War I

Stress-related combat injuries resurfaced with World War I. In that war, combat stress was more commonly known as shell shock. During World War I, the Army learned the basics of combat stress control from its Allies. The French and the British discovered that if stress casualties were evacuated to the rear, they were more likely to become chronic psychiatric problems. On the other hand, if the soldiers were quickly returned to their units, most recovered and returned to duty.

The Army Surgeon General at the time of World War I recommended a three echelon system for stress casualty prevention, identification, treatment, and return to duty. At the

first echelon, a psychiatrist was attached to every division. At the second echelon, the Army had a specialized neurological hospital, which was to provide brief rest and rehabilitation to the stress casualties that the psychiatrist was unable to return to duty. At the third echelon, a specialized base hospital near the rear provided several weeks of additional treatment. The three-echelon system worked well. Those principles of proximity, immediacy, and expectancy, known under the mnemonic PIE, are the basis of battlefield psychiatric casualty treatment today. We will provide more details on those principles later in this section.

## World War II

The lessons learned during World War I concerning the treatment of stress-related casualties were forgotten between World War I and World War II and had to be rediscovered after several disastrous experiences with stress-related casualties in the early battles. During World War II, combat stress was renamed combat or battle fatigue or combat exhaustion. The concept of PIE was reinstituted late in the war when a psychiatrist was ultimately assigned to each Army division.

Historical casualty data show that in the Mediterranean and European theaters the average incidence of combat stress casualties was one for every four wounded in action. When the intensity of the fighting increased, the ratio rose to one stress-related casualty for every two wounded in action. However, the casualties were treated quickly, near their unit, and 50 to 70 percent were returned to combat within 3 days, and most of the remaining returned within a few weeks.

In the Pacific theater, a much higher ratio of combat exhaustion casualties existed compared to actual wounded in action. There was one stress-related casualty for every wounded in action. Most of those, however, came from support units, not combat units. Most of the casualties were evacuated outside the unit, unlike within the European theater, and most did not return to duty. Our research did not go into the reasons for the historical differences between the theaters.

It was also during World War II that tough training and esprit de corps were shown to reduce battle fatigue casualties. Elite units had a relatively small ratio, less than 1 battle fatigue casualty for every 10 wounded in action. Also, unit cohesiveness reportedly resulted in less psychiatric-related losses.

## Korean War

Beginning with the Korean War, battle fatigue casualties became known as combat stress casualties. While combat stress casualties were high at the beginning of the war, during the late stages of the Korean War, the number of combat stress casualties was much smaller than in past wars. That occurred because of three major factors; two being preventive measures, the third being a treatment technique. Regarding the first major factor, the Services initiated a rotation system, 9 months in combat, 13 months in support units. For the second factor, the services

started rest and recreation periods for individuals and, if possible, whole units. For the third, a psychiatrist and veteran of World War II, Colonel Albert Glass, put into effect a combat psychiatry program based on the principles of treating the patient quickly near the unit.

### **Vietnam Conflict**

The incidence of combat stress casualties varied at different stages of the Vietnam Conflict. Early in the conflict, a complete psychiatric program was in place; combat stress casualties were low, only 2 percent of total casualties. In the middle phases of the conflict, that rate increased slightly, but remained relatively stable. In the later phases of the conflict, while the actual number of psychiatric casualties may appear low (10 percent of total casualties), the number of stress-related casualties was much higher, if all character and behavior disorders (such as drug abuse and addiction, alcoholism, and misconduct behaviors) are considered. By September 1971, neuropsychiatric cases accounted for over 60 percent of all medical evacuations from the theater.

### **Arab-Israeli Conflict**

The results of improperly treating combat stress casualties are evident in several Arab-Israeli conflicts. During the 1973 Yom Kippur War, the Arab surprise attack forced an Israeli piecemeal mobilization. As a result, Israeli units had minimal unit cohesion. Per Israeli estimates, many soldiers, including veterans, became unable to function solely due to stress. Without treatment plans in operation, those individuals were evacuated to Israeli hospitals; many of those individuals remained psychologically disabled. After the 1973 war, the Israelis instituted a medical and mental health support program. However, during the Lebanese invasion, many cases were inadvertently evacuated to Israel in the initial phase of the invasion. Few of the evacuated cases returned to full duty, while 60 to 80 percent of those treated in Lebanon did return to duty.

### **Desert Shield/ Desert Storm**

During Desert Shield/Storm of the 500,000 members deployed, 476 designated psychiatric casualties in the U.S. Army were evacuated from the theater. Psychiatric casualties represented less than 7 percent of all service members evacuated for medical reasons. The Army deployed three psychiatric detachments according to its newly evolving doctrine. The Navy supported the Marine Corps divisions by improvising combat stress centers at each surgical support company behind the Marine divisions. The Air Force deployed psychologists and technicians in the combat stress unit module of the air transportable hospital. The forward units were covered but combat stress control units were insufficient to cover the rear.

### **Peacetime and Operations Other Than War**

While the peacetime military missions today are not on the large scale of previous wars, control of stress related to those situations is still important. Deploying troops to foreign sites experiencing internal military conflicts places service members in stressful environments. Those individuals experience the same concerns as service members did in past wars, sudden death of

large numbers of service members, mission uncertainties, unknown environment, undefined or changing rules of engagement, and family concerns.

Examples of recent peacetime and military experiences in which stress was evident, and immediate treatment was needed, include the car bombing of the Marine barracks at the Beirut Airport, Lebanon; humanitarian assistance in Somalia and Rwanda; action to restore democracy in Haiti; and United Nations support in Bosnia.

For several of the key catastrophic events, psychiatric support intervention was provided. For example, a Navy special psychiatric intervention team was deployed to Lebanon; and teams from a combat stress control detachment were deployed to Somalia.

## **COMBAT STRESS AND COMBAT STRESS CONTROL PROGRAMS**

To understand combat stress control and the management of combat stress through a comprehensive program, we first need to explain combat stress, combat stressors, and combat stress reactions. In this section of the report, we will provide that information. We will also describe the elements of a comprehensive combat stress control program.

### **Combat Stress**

Combat stress is a process, within an individual, of reacting to and preparing to deal with physical and mental stressors occurring during combat-related duties or military operations. Those reactions can be in response to enemy action or from other sources, such as environment, mission demand, or the member's unit, leaders, or family.

Usually considered a negative process, combat stress appears under many names that convey that image. Those names include battlefield stress, shell shock, war neurosis, combat fatigue, battle stress reaction, and battle fatigue. Combat stress can, when properly focused by leadership, training, and informed command policy, result in positive reactions, such as extreme bravery, increased strength, or increased endurance.

### **Combat Stressors**

Combat stress is the body's way of reacting to combat stressors. Combat stressors are those events or situations occurring during a military conflict or operation that require a nonroutine adaptation or behavior change in the individual or pose a threat to the individual. Like combat stress, combat stressors can be both positive and negative. Positive stressors include promotion to new responsibilities; while negative stressors include the threat of death, combat stressors can also be either physical or mental. Figure 2-1 provides the more common types of combat stressors.

### ***Types of Combat Stressors*** (Physical and Mental)

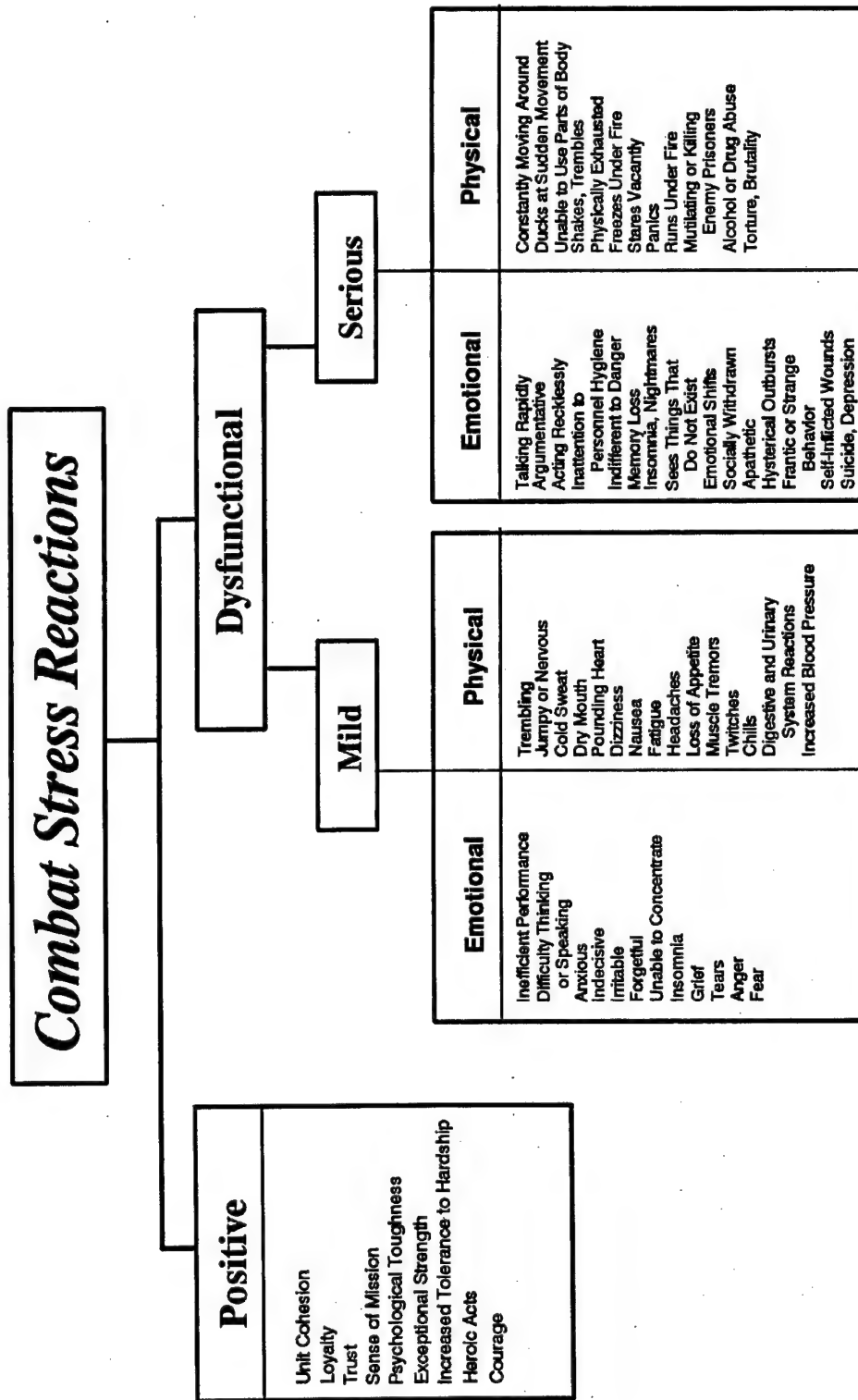
<b>Physical Stressors</b>	<b>Mental Stressors</b>
<b>Environment</b> Heat, Cold, Wind, or Sun Extreme Wetness or Dryness Vibration or Noise Fumes, Poisons, or Chemicals Infectious Agents or Diseases Physical Work Difficult or Arduous Terrain	<b>Cognitive</b> Information: Too Much/Too Little Ambiguity or Uncertainty Undefined or Changing Rules of Engagement Unpredictability Hard Choices Versus No Choices
<b>Physiological</b> Sleep Deprivation Dehydration Muscle Fatigue Illness or Injury Malnutrition Poor Hygiene Lack of Hot Food or Hot Showers	<b>Emotional</b> Fear of Death or Injury Fear of Personal or Mission Failure Bereavement, Witnessing Death Resentment, Anger, or Frustration Boredom Worries About Home Social Isolation

Note: The above stressors may act singly or interact with each other.  
Primary Source: Army FM 22-51, Leaders' Manual for Combat Stress Control.

**Figure 2-1**

### **Combat Stress Reactions**

Combat stress is more commonly described in terms of the combat stress reactions that occur because of the physical and mental stressors. Those stress reactions can be either positive or dysfunctional, mild or serious, and emotional or physical. While most reactions are normal, if dysfunctional stress reactions are not counteracted or refocused, either short- or long-term problems are possible. In addition, stress reactions will degrade combat and mission effectiveness. Figure 2-2 summarizes the most common combat stress reactions.



Primary Sources: Army FM 22-51, Leaders' Manual for Combat Stress Control; and Marine Corps FMFM 4-55, Combat Stress.

**Figure 2-2**

## **Combat Stress Control Programs**

Awareness of combat stress, stressors, and stress reactions resulted in the development of military combat stress control programs. Based on our review of selected literature, a comprehensive combat stress control program addresses the prevention, identification, and treatment of combat stress casualties. In this section we will provide a general overview of those three elements.

### *Prevention of Combat Stress Casualties*

Prevention is the first element of a comprehensive combat stress control program. Combat stress prevention affects all three structural processes, planning; implementation; and training. Planning for combat stress helps prevent combat stress and stress reactions during military missions or operations. Implementing combat stress prevention programs and processes results in reduced numbers of stress-related casualties. Adequately training service members in the quick identification and proper treatment of combat stress casualties can result in prevention of long-term psychiatric casualties.

### *Planning*

One example of prevention planning includes screening programs that are used to identify individuals having personality traits that may result in future dysfunctional combat stress reactions. The screening may be offered through tests that occur at several times throughout a service member's career, at time of recruitment, at time of accession, or before deployment. With that information, the military can identify individuals who may become symptomatic during a future mission or operation. Prevention planning also includes obtaining information through counseling or family advocacy programs on individuals who have family, financial, or physical problems that could later negatively affect an individual's performance, and ultimately a mission or operation's success.

### *Implementation*

Prevention is also important when implementing a comprehensive combat stress control program. Combat stress management is every military commander's responsibility. Prevention occurs when commanders take a proactive role by actively working to reduce or avoid controllable stressors, and instead focus the stress to promote positive behaviors. Examples of implementation of preventive stress control processes include providing service members mental and physical stimulation to decrease boredom and sufficient food and exercise while deployed to reduce physiological stressors. Other processes include keeping the service members informed through predeployment, in theater, and postdeployment briefings; providing prebattle briefings; providing debriefings when stressful incidents occur, such as bomb blasts; maintaining unit cohesiveness; and rotating service members between mission and support assignments, as done during the Korean War.

### *Training*

Prevention occurs through extensive training of service members at all levels, from the junior enlisted member to the senior officer. Service members are trained to be aware of stress, stressors, and stress reactions in themselves and fellow

service members. Senior officers are trained to identify the impacts of combat stress on mission performance. Training is also important for the chaplains and the medical professionals.

*Identification of  
Combat Stress  
Casualties*

Identification of potential and actual combat stress casualties is the second major element of a comprehensive combat stress control program. Identification can occur during predeployment, in theater, or postdeployment. Predeployment screening includes identification of potential problem individuals from as early as the time of recruitment to immediately before deploying to the mission or operation theater. In theater identification is the responsibility of the unit members and leaders. With proper training, combat stressors and stress reactions can be readily identified. Postdeployment identification, if delayed, may lead to long-term psychiatric problems.

*Treatment of  
Combat Stress  
Casualties*

Treatment, like the previous two elements, is the responsibility of every service member (from the junior enlisted member to the senior officer) and especially those involved with medical and chaplain services. However, the type of treatment varies with the echelons of medical care.

*Echelons of  
Medical Care*

Echelons of care are the distribution of medical resources and medical capabilities to facilities at various levels of function and distances from the battlefield. Each level of function or distance is an echelon of care for which there is prescribed medical care capabilities. As the distance from the battlefield increases, the medical capabilities increase; however, mobility and flexibility decrease. The concept of echelons of care is important because it defines the type of health care a military medical officer would provide to the casualty at that echelon. The following describe the capability provided at each of the five echelons.

- Echelon 1 care is medical care provided on the front line of the battlefield. It includes self aid and buddy aid, and involves emergency first aid, relief of pain and comfort, and prioritization for medical evacuation.
- Echelon 2 care is medical care provided in the rear of the battlefield by a team of medical personnel supported by a level of facilities, medical supplies, and equipment. It is sufficient either to stabilize casualties for further evacuation to more definitive care or to treat the casualty for return to duty. For stress cases, this echelon provides outpatient counseling or the individual is held 1 to 3 days for rest or restorative activities.
- Echelon 3 care is medical care provided in the combat zone at facilities staffed and equipped to provide resuscitation, initial wound injury, and postoperative treatment. For stress casualties, this echelon provides hospital diagnostic capabilities and the individual is held 1 to 2 weeks for reconditioning treatment.

- Echelon 4 care is medical care provided in the communications zone at general hospitals staffed and equipped for definitive care, with a mission to rehabilitate casualties to duty status.
- Echelon 5 care is medical care provided at health care facilities in the continental United States, both government and civilian.

*Combat Stress  
Treatment  
Principles*

Studies on the subject, and historical data regarding battle casualties, document that three principles are critical to the successful recovery or treatment of a service member suffering from combat stress. First documented during World War I by Colonel Thomas Salmon, MD, the PIE principles have become the basic tenets of psychiatric combat medicine. The PIE principles follow.

- P - Proximity: Management of the combat or battle fatigue casualty should be as near as possible to the battle line or the service member's unit.
- I - Immediacy: Management of the combat or battle fatigue casualty should begin as soon as the condition is recognized.
- E - Expectancy: Combat casualties should be constantly reminded that they have an acceptable and temporary reaction, the condition will quickly improve, they will be able to return to their unit soon, and they will be able to perform their duties competently.

As more knowledge has been gained regarding the improved methods for handling combat stress casualties, the PIE principles have been expanded. The commonly accepted expanded principles are known under two other recognized mnemonics, BICEPS (brevity, immediacy, centrality, expectancy, proximity, and simplicity) and IMPRESS (immediacy, military milieu, proximity, rest and replenishment, expectancy, simplicity, and supervised in a military role). The concept of BICEPS includes the three PIE principles plus the following.

- B - Brevity: Treatment should be brief. If the combat stress casualty is not able to return to duty within 3 days, the individual should be evacuated to the rear.
- C - Centrality: Individuals should be treated in a central location to reduce their identification as patients.
- S - Simplicity: Treatment should be short and simple. Complex psychotherapeutic techniques and drug therapy should be avoided.

The third accepted expanded principle, IMPRESS, is based on the PIE principles, simplicity as outlined in BICEPS, and the following.

- M - Military milieu: The individual should be treated in a military environment, not as a patient in a hospital.
- R - Rest and replenishment: Appropriate rest and replenishment should be provided whenever possible.
- S - Supervised in a military role: Similar to centrality in the BICEPS principles, treatment is best done by one specific military member who clearly understands the treatment goals and does not treat the individual as a patient, but instead as a military member in a military environment.

In addition to the above principles, which are primarily the responsibility of the line, medical personnel are involved in the treatment program. Treatment can be handled through on-site psychiatrists, combat stress teams, or other trained personnel. More detail concerning the types of treatment programs offered by the individual Services will be outlined in the Results of the Evaluation section of this report.

#### **SUPPLEMENTAL STRESS CONTROL PROGRAMS**

Supplemental stress control programs are those programs available to service members with personal, financial, and other noncombat stress related problems. The programs are also available to family members, even during periods when the service member is deployed. Examples of supplemental programs are crisis assistance, exceptional family members, family advocacy issues, family life education, physical fitness, relocation assistance, stress management, and substance abuse.

- Crisis assistance programs - provide immediate, short-term assistance in response to an acute crisis, such as a death in the family.
- Exceptional family member programs - provide medical, educational, or community support, for family members with special needs. Those family members can include persons who have educational, mental, and physical disabling conditions.
- Family advocacy programs - provide support regarding family violence, child abuse, and other aspects of the family structure. The primary goals are prevention, education, treatment, and reporting.
- Family life education programs - provide support to individuals, couples, and families, concerning family and social issues, by enhancing self-esteem, strengthening interpersonal competencies, and offering education on family roles and responsibilities.

- Physical fitness programs - while every service member is responsible for maintaining his or her fitness for duty, physical fitness includes more than maintaining an appropriate weight and exercise level. It also includes reducing or eliminating tobacco use, back injury and strain prevention, and other issues relating to health and fitness.
- Relocation assistance programs - provide assistance to service members and their families when relocating to a new duty station.
- Stress management programs - provide education and support in managing stress; understanding the effects of stress on individual health and performance; and recognizing the stressors associated with one's personal, professional, and military life.
- Substance abuse programs - provide service members with programs and initiatives that prevent drug and alcohol abuse and addiction, and provide rehabilitative services when needed.

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## PART III - RESULTS OF THE EVALUATION

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Our evaluation of combat stress control management focused on the three structural processes of planning; implementation; and training. We examined those structural processes as they related to combat stress control management in DoD, including the OASD(HA), the Joint Staff, and the Services. Additionally, we evaluated each Service's specific combat stress program with regard to the three major elements of a comprehensive combat stress control program from the time of predeployment through redeployment.

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### A. PLANNING

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We concentrated on deliberate planning (a part of strategic planning) and operational planning. Deliberate planning is a process of the Joint Operation Planning and Execution System involving the development of joint operations plans and concepts for contingencies identified in joint strategic planning documents. Operational plans are any plans, except single integrated operational plans, for the conduct of military operations. The operational plan identifies the forces and supplies required to execute a unified commander's strategic plan in a specific operation.

The DoD is addressing planning for combat stress casualties through both its deliberate and operational planning. Planning for battle fatigue casualties is included in a May 1995 Joint Staff instruction. Battle fatigue casualty rates have been built into the DoD medical planning software. Combat stress is indirectly addressed in the DoD Medical Readiness Strategic Plan 2001 (MRSP 2001).

#### JOINT STRATEGIC PLANNING SYSTEM AND JOINT STRATEGIC CAPABILITIES PLAN

At the joint level, military planning is conducted within the framework of the Joint Strategic Planning System. The Joint Strategic Planning System establishes the administrative framework for the chairman, in consultation with the other members of the Joint Chiefs of Staff and the Commanders in Chief (CINC) of the Unified Commands, to provide strategic operational guidance to the Armed Forces. Included in the Joint Strategic Planning System is the Joint Strategic Capabilities Plan, which provides guidance to the CINC and the heads of the Services to accomplish tasks and missions based on current military capabilities. The Joint Strategic Capabilities Plan apportions resources to the CINC based on military capabilities resulting from completed program and budget actions. Incorporated into the Joint Strategic Capabilities Plan are supplements supporting various components of Service requirements. Medical issues are addressed in the "Logistics Supplement to the Joint Strategic Capabilities Plan."

**Logistics  
Supplement to the  
Joint Strategic  
Capabilities Plan**

The Chairman of the Joint Chiefs of Staff issued Instruction 3110.3, "Logistics Supplement to the Joint Strategic Capabilities Plan," on May 3, 1995. That instruction provides planning guidance to the CINC, the heads of the Services, and DoD agencies in support of the logistics requirements for joint operations. Enclosure E of the Logistics Supplement, "Health Service Support Planning Guidance," addresses medical resource planning.

**Inclusion of Combat  
Stress Planning in  
the Logistics  
Supplement**

The Health Service Support Planning Guidance includes planning for combat stress casualties as part of medical resource planning. Specifically, for hospitalization planning, the guidance states, "Current Service-approved casualty rate planning factors should be used for each scenario. However, when MPM 2.0 [MPM 2.0 is Medical Planning Module Version 2.0, which is also known as the Medical Planning Execution System (MEPES)] is operational, separate Service rates may be required for each casualty category: Wounded; Disease, Non-Battle Injury; Died in Hospital; Killed; Captured; Missing in Action; Administrative Loss; **Combat Stress/Battle Fatigue** [emphasis added]; Unconventional Injuries or Illnesses." In addition, for primary care planning, the guidance states, "Plans must ensure responsive intervention of combat stress teams to minimize stress and psychiatric casualties."

**MEDICAL PLANNING  
SOFTWARE  
AVAILABLE**

Medical planning software is constantly evolving. Currently, the CINC and the Services are using the Medical Planning Module (MPM) of the Joint Operation Planning and Execution System to project medical resource requirements. However, that system is being replaced by MEPES, also known as MPM 2.0. MEPES will ultimately be supplemented with the Logistics Processor External-Medical (LPXMED). Each system is described below.

**Medical Planning  
Module (No Combat  
Stress Planning)**

The MPM was developed in response to the DoD planning community's need for a consistent means of projecting and evaluating medical requirements in support of operational plan development. The MPM was designed to be compatible with the organization and unit structure of each of the Services and to recognize the unique requirements of each Service. With respect to medical planning specifically for combat stress, none exists within the MPM. Instead, the MPM includes combat stress casualties as part of the category nonbattle injury.

**Medical Planning  
Execution System  
(Includes Combat  
Stress Planning)**

For planning purposes, DoD deemed the nonbattle injury category in the MPM insufficient. To correct that deficiency, the patient casualty estimation categories were expanded with the replacement system, the MEPES. MEPES is an operational information management system programmed to be the medical module in the DoD Global Command and Control System, integrating theater military health care requirements and capabilities within the military and civilian health care system in the continental United States. MEPES incorporates and enhances the functionality of the MPM. More importantly for this

evaluation, population at risk and total casualty estimations under MEPES include battle fatigue in the medical planning factors. The Joint Staff informed us that the MEPES will be used to prepare the FY 1996 operational plans.

**Logistics Processor  
External-Medical  
(Includes Combat  
Stress Planning)**

As we explained earlier, MEPES is being supplemented with the system called LPXMED. LPXMED provides a simulation of the medical processes that would occur within a theater of operations. That system will be part of the Joint Operation Planning and Execution System medical planning capability, adding significant depth to the capabilities of the MEPES. Using the LPXMED simulation capability, planners will be able to:

- test courses of medical action that may be more responsive to the operations plan and demonstrate the impact of the improved support.
- assess the medical impact of delays in the arrival of critical forces and test alternatives.
- optimize the effectiveness of the total force by taking advantage of medical logistic strengths and minimizing the impact of medical logistic weaknesses.

The LPXMED modules provide the logistician the same capabilities to wargame the most effective use of forces that are available to the tactician.

As with MEPES, the LPXMED system also includes battle fatigue as a medical casualty rate planning category. The Joint Staff informed us that the CINC and the Services will use LPXMED to develop the FY 1997 operational plans.

**Medical Planning  
System Summary**

While the previous medical planning system, the MPM, did not adequately support planning for combat stress casualties, DoD has identified and corrected the deficiency. Beginning with FY 1996, and continuing over the next two fiscal years, DoD will implement system enhancements that include both resource planning for combat stress casualties and wargaming to maximize the DoD medical logistics capabilities. MEPES and ultimately LPXMED will provide DoD staff with the capability to address combat stress and battle fatigue as a medical threat requiring medical resource planning.

**MEDICAL  
READINESS  
STRATEGIC  
PLAN 2001**

The MRSP 2001 is an integrated, coordinated, and synchronized plan for achieving and sustaining medical readiness through the year 2001 and beyond. Finalized in March 1995, the plan was developed by a team of subject matter experts from the OASD[HA], in coordination with the Joint Staff, the Office of the Secretary of Defense, the Military Departments, the Unified Commands, and various Defense agencies. The team of experts prepared 42 action plans addressing issues critical to medical readiness. Of those action plans, four described below, relate indirectly to combat stress medical planning.

**Several Action Plans  
Support Combat  
Stress Planning**

Four action plans are included in the MRSP 2001 that indirectly support combat stress casualty planning as part of medical readiness resource planning. When those plans are implemented, combat stress casualties will be totally incorporated into the planning process. They are:

- action plan 4 - second through fifth echelons and MEPES planning factors.
- action plan 6 - casualty rate development compilation and application methodology.
- action plan 7 - incorporate medical participation into wargaming models and simulations.
- action plan 8 - patient stream specification.

*Action Plan 4*

The objective of action plan 4 is to establish planning factors for the second through fifth echelons based on the time, task, treater clinical data base developed by the Defense Medical Standardization Board. [The time, task, treater clinical data base is a component of the Deployable Medical System data base, which is used to collect and process clinical and logistical data to produce standardized medical materiel sets. The data base includes patient condition codes, echelon information, functional areas performing the treatment, time required, both initial and recurring, materiel used, and percentage of patients.] Those factors are developed only for the third and fourth echelons. In addition, the action plan requires annual validation of the planning factors in the MEPES. Since the time, task, treater clinical data base includes stress-related casualties, completion of this action plan to include the second and fifth echelons is critical for the medical readiness planning of combat stress.

*Action Plan 6*

The objective of action plan 6 is to develop a methodology for each Service to ensure a match of casualty category rate development and application across the full range of operational situations. The MPM, which determines wartime health service requirements, is often misapplied and medical resources may be overstated or understated. Completion of the tasks supporting this action plan should result in more accurate planning for casualties, including combat stress and battle fatigue casualties, with casualty rates identified by operational situations.

*Action Plan 7*

The objective of action plan 7 is to add medical requirements to all wargaming activities and develop interfaces between wargaming tools and existing and future medical models. Adding medical participation to wargaming models would allow casualties generated by such exercises to be fed directly into the medical requirements generators. Casualty estimates would then parallel planned combat operations. The action plan discussion indicates that the effects of disease, not battle injury, would be

added to the wargaming models. However, combat stress is not specifically addressed as part of the disease, not battle injury, category.

#### *Action Plan 8*

The objective of action plan 8 to develop a method of linking real world patient load data with patient condition codes enabling planners to forecast medical work load and resource requirements. Patient condition codes developed by the Defense Medical Standardization Board are not based on the International Classification of Diseases - Ninth Revision, which is used in the Composite Health Care System, the DoD hospital information system. Currently, the patient conditions include nine codes specifically for stress reactions, two indirectly related to combat stress (psychosis and conduct disorders) and others that address drug and alcohol use. Completion of the action plan will allow the patient condition codes to be defined in terms of aggregate International Classification of Diseases - Ninth Revision codes and ensure time, task, treater data are provided for each patient condition code.

#### **Implementation Timelines Should be Developed and Followed**

Developing the action plans is only the first step. In his Message From the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) included with the MRSP 2001, the ASD(HA) states, "We must turn these action plans into 'implementation plans' for execution." The implementation plans to be developed are to have timelines identified for each task and an organizational element responsible for ensuring that those timelines are met. We support the ASD(HA) request. Realistic milestones will need to be agreed upon and the implementation plans will have to be resourced. An organizational element will need to be assigned primary responsibility for coordinating and executing each action plan.

#### **Action Plan Summary**

Action plans in the MRSP 2001 require the use of a time, task, treater clinical data base in medical planning. That data base allows patient conditions, defined by the Defense Medical Standardization Board, to be linked to the appropriate treatment so that data on patient load can be converted to projections of medical resources required. The plans include linking patient conditions to International Classification of Diseases - Ninth Revision codes and building medical planning into the wargaming systems. When those codes are implemented, the systems can readily reflect combat stress as a medical wartime planning factor. All affected organizations are actively involved in coordinated efforts to develop the needed action plans--the OASD(HA), the Joint Staff (Logistics Directorate, Medical Readiness Division), the Defense Medical Standardization Board, and the Military Departments. OASD(HA) staff stated that it has not received all the implementation plans for the four action plans relating to combat stress management, but it is monitoring the receipt of them.

**PLANNING  
SUMMARY**

The Joint Staff, the OASD(HA), and the Services have or will have combat stress casualty rates built into their medical resource planning. The Joint Staff Instruction requires battle fatigue as a medical planning condition. The new medical planning software will include battle fatigue as a population at risk casualty planning factor. Also, the MRSP 2001 addresses the need to improve medical readiness planning and ties medical readiness planning to the patient condition codes that include stress reactions.

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**Recommendation 1**

The Assistant Secretary of Defense (Health Affairs), in coordination with the Joint Staff, the Defense Medical Standardization Board, the Military Departments, and the Defense Modeling and Simulation Office, should continue all activities necessary to implement action plans 4, 6, 7, and 8, outlined in the Medical Readiness Strategic Plan 2001, in order to incorporate fully combat stress casualty estimates into the medical planning programs used by the Commanders in Chief of the Unified Commands and the Service heads. In addition, the Assistant Secretary of Defense (Health Affairs) should ensure that implementation plans have realistic milestones set and are adequately resourced.

**Management Comments**

The ASD(HA) concurred with the recommendation. He indicated that his staff is actively engaged in oversight of the timely implementation and resourcing of the component action plans of the MRSP 2001. The Army, Navy, Air Force, and the Joint Staff also concurred with the recommendation. The full text of all management comments is in Part IV.

**Audit Response**

Comments from the ASD(HA) are responsive. An individual in the OASD(HA) is dedicated to tracking the Military Department and Defense agency actions required by each action plan.

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## B. IMPLEMENTATION

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Implementation of combat stress control programs is the responsibility of several major components within the DoD, including the Office of the Secretary of Defense; the Joint Staff; and the Services. In this section we will summarize the results of our data collection and analysis related to combat stress control programs and management at those DoD levels. We will address the organizational responsibilities, the existence of written policies and doctrines, and the completeness of combat stress control programs within each Service.

### OFFICE OF THE SECRETARY OF DEFENSE

Within the Office of the Secretary of Defense, the primary organizational component responsible for the management of combat stress matters is the OASD(HA). Based on the literature search and our interviews with staff in the OASD(HA), no DoD policies, directives or instructions, exist that specifically address combat stress control or the need for combat stress control programs within the Services.

### Role of the Office of the Assistant Secretary of Defense (Health Affairs)

It was extremely difficult for us to collect definitive information concerning DoD policies regarding combat stress control because no one individual or organizational element within the OASD(HA) is specifically responsible for combat stress control and management. Control of combat stress and development of combat stress control programs are medical readiness issues. Within the OASD(HA), responsibility for supporting medical readiness resides with the Deputy Assistant Secretary of Defense (Health Services Operations and Readiness). However, combat stress is a clinical condition, and clinical issues are the responsibility of the Deputy Assistant Secretary of Defense (Clinical Services).

The primary point of contact assigned to our evaluation was from the Office of the Deputy Assistant Secretary of Defense (Clinical Services) because combat stress is categorized as a clinical condition, and more specifically, a mental health clinical condition. While mental health conditions are being handled by the Office of the Deputy Assistant Secretary of Defense (Clinical Services) staff, combat stress as a critical mental health condition and combat stress control as a medical readiness issue are not specifically covered by OASD(HA) staff. Historical data show that combat stress casualties can account for up to 60 percent of all medical casualties, therefore, we considered the lack of comprehensive oversight by OASD(HA) staff as a management weakness.

A central point of contact within DoD is needed to ensure adequate oversight of combat stress matters and combat stress control programs. That central point of contact would be responsible for policy and coordination of the planning,

implementation, and training requirements related to combat stress control. It would be logical for the ASD(HA) to fulfill that role.

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**Recommendation 2**

The Assistant Secretary of Defense (Health Affairs) should formally assume functional responsibility for policy, coordination, and oversight of the planning, implementation, and training related to combat stress control within the Department.

**Management Comments**

The ASD(HA) concurred with the recommendation. He indicated that the DoD Medical Program Guidance specifies the overall functional responsibility of the ASD(HA) for policy, coordination, and oversight of the DoD Medical Program. Specific responses to the key elements of health care support are included in the Readiness Core Area section of the DoD Medical Program Guidance. To implement our recommendation, the OASD(HA) staff will add language to the readiness core area section of the draft DoD Medical Program Guidance for fiscal years 1997 to 2001 being written to focus appropriate attention on combat stress control. The Army, Navy, Air Force, and the Joint Staff also concurred with the recommendation.

**Audit Response**

Comments from the ASD(HA) are responsive.

**JOINT STAFF**

Within the Joint Staff, the primary office responsible for combat stress control and management is the Medical Readiness Division, Directorate for Logistics. The Medical Readiness Division is responsible for promulgating doctrine related to joint medical operations.

**Joint Medical  
Doctrine**

The Joint Staff Officers Guide 1993 defines joint doctrine as the fundamental principles issued by the Chairman of the Joint Chiefs of Staff that guide the employment of forces of two or more Services in coordinated action toward a common goal. Until recently very little joint medical doctrine had been published. However, several joint medical doctrine publications are now in either draft or final release.

- Joint Field Manual (Army Field Manual 8-285, Navy Medical Manual P-5041, and Air Force Manual 160-11), "Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries," February 1990.
- Joint Publication 4-02, "Doctrine for Health Service Support in Joint Operations," November 15, 1994.
- Draft Joint Publication 4-02.1, "Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations," November 1994.
- Draft Joint Publication 4-02.2, "Joint Tactics, Techniques, and Procedures for Patient Evacuation in Joint Operations," April 1995.

**Health Care  
Delivery in  
Joint Operations**

In our interviews with members of the Joint Staff, they indicated that whenever the Services are involved in joint operations, there should be a joint doctrine. They also said that more frequent joint health care operations were occurring, especially as part of peacetime missions and operations other than war. For example, in Croatia, medical support for all military members is rotated among the Services. In Haiti, the Army provided all health care for service members in the region. An example of jointness in health care delivery specifically related to combat stress control was the Army 528<sup>th</sup> Combat Stress Control Detachment deployment to Somalia. The Detachment provided stress control counseling to the Marines following two combat deaths and a suicide aboard a Navy ship. At Guantánamo Bay, Cuba, the Army Combat Stress Control Company and Detachment teams deployed and worked with Air Force air transportable hospitals and Navy neuropsychiatric personnel to treat Cuban and Haitian transient inpatient and outpatient psychiatric patients, and to provide combat stress control for U.S. troops.

Stress associated with those, and other, peacetime missions and operations other than war can occur among service members, regardless of Service affiliation. Handling this mission-related stress can be provided by any trained medical staff member.

Although treating mission or combat stress casualties is not generally considered a Service-unique issue, we did not find formal interoperability among the Services, except when the Navy provides health care services to Marine Corps members. Treatment of mission or combat stress is not solely handled by members of the casualty's Service. Treatment of combat stress is a joint issue.

**Joint Doctrine  
Addressing Combat  
Stress Needed**

Based on our analysis of this issue and our understanding of joint doctrine, we support the issuance of joint doctrine that addresses combat stress control and management. Only Joint Publication 4-02 includes combat stress. Appendix A of that publication, Medical Threat, identifies casualties caused by combat stress as one of the medical threat elements with the greatest potential for force degradation during combat operations. This is an excellent beginning. However, additional doctrine is needed that more fully addresses prevention, identification, and treatment of combat stress casualties. Because joint doctrine addresses the fundamental principles that guide operations involving two or more Services, and joint doctrine generally covers broad issues, we do not support a joint doctrine devoted exclusively to combat stress control. Although the precedent exists for issuing a doctrine devoted solely to one type of medical casualty (such as the joint field manual on chemical casualties), we do not support a joint doctrine solely for combat stress for one major reason, issues relating to combat stress have too many Service-unique aspects, especially with respect to prevention and identification.

*Prevention and  
Identification  
Generally  
Service-Unique*

Combat stress control programs have three major elements, prevention; identification; and treatment. For prevention and to some extent identification, the requirements are generally unique to the individual Service. Because of the physical location of the Navy and the Air Force units in combat operations (that is, usually out of the line of fire), their programs will have different characteristics and requirements than those of the Army or Marine Corps, who generally conduct ground operations. While the Air Force and Navy face unique dimensions of stress in the air and on the sea, the Army and Marine Corps service members will likely experience more sustained types of intense combat stressors. For that reason, we conclude that the prevention and identification elements will have some Service-unique aspects.

*Treatment is  
not Usually  
Service-Unique*

Treatment, on the other hand, is usually not Service-unique because once diagnosed with combat stress, commonly accepted treatment procedures are universally applied. Soldiers, sailors, airmen, and marines experiencing combat stress all should be treated in the same manner. A treatment program for combat stress casualties includes treatment at the five echelons. While echelon 1 (battlefield-front) and possibly echelon 2 (battlefield-rear) may have some Service-unique elements, treatment at the remaining three echelons should be the same. In addition, the treatment received by combat stress casualties could be provided by medical professionals from any Service.

**Combat Stress  
Joint Doctrine  
Alternatives**

We conclude that combat stress control should be incorporated into a joint doctrine that addresses the prevention, identification, and treatment of combat stress in joint operations. We do not support a joint doctrine that covers only combat stress, and offer two alternatives. First, a joint doctrine could be developed for the treatment of mental health conditions resulting from joint operations and conflicts. That doctrine could include behavioral and drug problems, as well as combat stress. Second, a joint doctrine could be developed that addresses the treatment of combat-related injuries, including combat stress.

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**Recommendation 3**

The Joint Staff, in coordination with the Assistant Secretary of Defense (Health Affairs) and the Military Departments, should incorporate combat stress management guidance into a joint doctrine. The guidance should address combat stress prevention, identification, and treatment in joint operations; consider Service-unique requirements; and be included in a joint doctrine that addresses broader health care issues associated with joint operations.

**Management Comments**

The Joint Staff concurred with the recommendation. The Army, Navy, Air Force, and the ASD(HA) also concurred with the recommendation.

**Audit Response**

Management comments were responsive.

## THE SERVICES

Each Service addresses combat stress control differently. In this section of the report, we will describe the combat stress control programs in the Services and any Service-unique doctrine addressing the subject. [By doctrine, we mean published fundamental principles that guide the employment of forces, as defined in Joint Publication 1.] In addition, we will briefly discuss the roles of both medical and nonmedical command elements and explain the relationship between combat stress control and supplemental stress control programs.

### Service Combat Stress Control Programs

Each of the Services handle combat stress control differently. The Army and the Marine Corps have comprehensive programs that cover most aspects of combat stress management. The Navy has a program that primarily focuses on noncombat crisis management. The Air Force is beginning to address the issue. A summary of the programs follows.

#### *Army*

The Army program is excellent. It covers all three elements of a comprehensive combat stress control program. The Army has published doctrine concerning combat stress control. It has also designated a primary point of contact responsible for combat stress control.

The Army combat stress control program doctrine addresses prevention, identification, and treatment of combat stress casualties. That doctrine also describes the combat stress control companies and combat stress control detachments.

#### *Combat Stress Control Companies*

Combat stress control companies are medical companies devoted solely to the prevention and treatment of combat stress casualties. Each company is organized into a headquarters section, a preventive section, and a restorative section. The headquarters section consists of a commander (psychiatrist), medical operations officer, chaplain, and 13 enlisted members providing support. The preventive section provides preventive consultations and assistance. It contains 6 psychiatrists, 6 social workers, and 12 behavioral science specialists that can be divided into teams. The restorative section provides neuropsychiatric identification, diagnosis, stabilization, treatment, and disposition to return the casualty to duty. It can also be broken into teams and includes 4 psychiatrists, 4 clinical psychologists, 4 occupational therapy officers, 4 patient administration specialists, and 28 enlisted medical specialists. A company provides comprehensive combat stress control support to a corps with two or more Army divisions. The number of divisions supported varies with the intensity of the conflict, that is, the higher the intensity, the less divisions supported.

#### *Combat Stress Control Detachments*

A combat stress control detachment is a 23-person unit composed of a headquarters, combat stress preventive section, and combat stress restorative section. Detachments are similar to but smaller than modular teams in the combat stress control companies. Headquarters consists of a psychiatrist and the detachment commander, who is supported by a noncommissioned

officer in charge. Each preventive section contains three psychiatrists, three social workers, and six behavioral science specialists. Each restorative section consists of an occupational therapy officer, a psychiatric nurse, a clinical psychologist, and six enlisted behavioral specialists. The medical detachment provides comprehensive support to a division, or two to three separate brigades or regiments.

#### *Army Doctrine*

Army Doctrine on combat stress control is extensive. Field Manual 22-51, "Leaders Manual for Combat Stress Control," September 1994, discusses preventive techniques, identification of combat stress casualties, and the treatment of those casualties. The manual discusses combat stress in military operations as well as operations other than war. Leaders (especially line commanders) are provided with the information they need to lead troops through combat stress provoking crises.

Field Manual 8-51, "Combat Stress Control in a Theater of Operations," September 1994, discusses control of combat stress, mental health, and combat stress control elements in the theater of operations (such as mental health units, combat stress control companies, and combat stress control detachments). The manual also includes combat stress control operations in the combat zone and other tactics, techniques, and procedures the Army uses for handling combat stress and combat stress casualties. Other than field manuals, the Combat Stress Action Office has developed booklets and pocket cards for Army leaders in the field.

#### *Primary Point of Contact*

A primary point of contact for combat stress control has been designated within the Army. The point of contact is the Combat Stress Action Office, Department of Preventive Health Services, Army Medical Department Center and School, U.S. Army Medical Command. The office includes a psychiatrist, who is the chief, and a noncommissioned officer providing support.

#### *Marine Corps*

Although not as complete as the Army program, the Marine Corps program is also comprehensive. Its policy is summarized as, "forces may experience . . . higher ratios of stress unless small-unit leaders are trained and prepared to manage stress. Combat stress is a command problem."

#### *Combat Stress Platoons*

The Marine Corps program is incorporated as part of the United States Marine Corps Medical Battalion structure that includes a combat stress platoon (composed of one psychiatrist, two psychologists, and three psychology technicians) in each of three surgical companies. Surgical companies are designed to collocate with other combat service support elements in the combat zone and provide echelon 2 (battlefield-rear) services to casualties. In the event of a combat or operational deployment, if the Marine Corps identifies a need for a full medical battalion, the Navy would provide the augmentees to staff the platoons. The Navy identified staffing the full Marine Corps medical

battalion as a readiness requirement, and said that it will support the Marine Corps when a request is received to activate the combat stress platoon.

*Marine Corps  
Doctrine*

For the Marine Corps, the basic doctrine concerning combat stress control is Fleet Marine Force Manual 4-55, "Combat Stress," April 1992. The purpose of that doctrine is to enable small unit leaders to prevent, identify, and treat combat stress for themselves and Marines in their command.

*Navy*

The Navy has no formal combat stress control program. No central point of contact is responsible for the management of combat stress for the Navy. Although the Navy has not published doctrine that supports combat stress control, "Handbook of Aviation and Operational Psychiatry," the Naval Aerospace and Operational Medical Institute, references combat stress for Navy service members. However, the Navy does not have a documented method, program, or process addressing the prevention, identification, or treatment of combat stress casualties, nor does it provide any mental health support for its forces afloat.

*Need for Formal  
Combat Stress  
Control Program  
Recognized*

Based on our interviews and review of memoranda and reports, Navy members have identified a need for a combat stress management program. Lessons learned regarding mental health services aboard the *USNS Comfort* in support of Operations Desert Shield and Desert Storm identified weaknesses in the Navy mental health program. The standard stressors were present, unpredictability, physical stress, lack of information, worries about home, boredom, and fear. Sailors stress reactions showed the need for a program. However, none is planned aboard the ship.

*Special Psych-  
iatric Rapid  
Intervention  
Team*

One Navy program that addresses stress control and mental health support for Navy service members is a peacetime, single-incident, crisis intervention program called the Special Psychiatric Rapid Intervention Team (SPRINT). A SPRINT team is a multi-disciplinary team that provides supplementary and direct crisis intervention services to individuals, commands, and communities coping with traumatic events (for example, shipboard fires, suicide of a service member, or an emotionally charged incident such as the explosion on the *USS Iowa*.) SPRINT teams do not deploy during or before military operations but after a major incident occurs. A full SPRINT team consists of 11 members comprised of 2 psychiatrists, 2 clinical psychologists, 1 psychiatric nurse, 1 chaplain, 1 social worker, and 4 neuropsychiatric technicians. Generally, a partial team, usually two to five trained members, can be tailored to the size of the incident. The identification and treatment processes used by the SPRINT teams are similar to the proven techniques used for combat stress control.

*Air Force*

The Air Force does not have a formal combat stress control program. The Air Force capability for combat stress control is very limited. It has crisis response teams, similar to the Navy SPRINT teams; however, those teams do not receive the extensive training provided the SPRINT teams. Although the Air Force air transportable hospitals and clinics have mental health support for combat stress casualties, they are designed for the limited environment of an airfield operation. Although the Air Force identifies mental health teams as the need arises; it is working to formalize the program.

*Air Force Scope of Practice Conference*

During a Scope of Practice Conference held in December 1994, the Air Force mental health subgroup identified the need to establish the following teams or modules to support mental health problems, including combat stress casualties.

- Mental health rapid response teams (designated teams for rapid deployment).
- Mental health basic deployment module (for stress reaction or psychiatric casualties, for mission support).
- Mental health expanded care and augmentation module (for additional stress reaction and psychiatric casualties, in support of aeromedical staging facility and aeromedical evacuation missions).

As part of the proposed new mental health capability, the Air Force will provide support for readiness missions, including pre-deployment briefings, mental health modules, training, and health promotion. The proposed teams and modules were approved by the Air Force Surgeon General in mid 1995 and are being tested.

*Summary of Service Programs*

Programs offered by the Services concerning combat stress control vary greatly. This variation will affect the Services deployment response and readiness posture and could have major implications for joint force commanders. The Army's program is comprehensive and combat stress medical teams are always staffed. The Marine Corps has a comprehensive program, but relies on the Navy to staff the combat stress control platoons that could impact its medical readiness. While the Navy does not have a combat stress control program, it does provide support to the Marine Corps and has pretrained, preidentified SPRINT teams for identified peacetime crises. The Air Force is beginning to develop a combat stress control program and mental health teams.

**Roles of Medical and Nonmedical Command Elements**

Three major groups of personnel are key to a successful combat stress control program, line commanders, medical staff, and chaplains. Personnel from all Services agree that each group plays an important role. Line commanders ensure the troops are adequately trained in identifying and immediately supporting the combat stress casualty. The medical staff, especially the mental health staff, provide treatment to the patient so he or she can be

returned to duty. The chaplains provide the spiritual and ethical support required as part of a total treatment program. The training of those personnel will be discussed in the next section of the report. Incorporating those three groups as key players in combat stress management is important for the implementation of quality combat stress control programs.

#### **Role of Supplemental Stress Control Programs in Combat Stress Management**

Supplemental stress control programs are important during peacetime, but they also play a significant role in predeployment activities in support of the prevention of combat stress. Leaders need to know as much as possible about the individuals being deployed with them. Supplemental stress control programs help in attaining that knowledge. For example, if a service member is experiencing a noncombat stress condition (for example, health, financial, or other personal problems) and the individual is being counseled through one of the Services' supplemental stress control programs, that information should be provided to the service member's commanding officer. Before deployment, that information will be crucial in identifying individuals who may be more vulnerable to combat stressors.

While commanding officers are sometimes provided the information they need concerning their troops, the Services did not have a formal method for communicating that information. In our opinion, part of a comprehensive prevention program includes a method for obtaining information about the personnel being deployed, within Privacy Act restrictions. With that information, the commanding officers can start early identification of individuals with a high risk of experiencing combat stress and provide treatment, if necessary.

#### **Services Summary**

Effective combat stress management by the Services requires three actions. The Services need a program to address combat stress casualty prevention, identification, and treatment. Two of the Services discussed in this report have such a program; two do not. The Services need to ensure the line, the medical staff, and the chaplains are part of that program. While medical and chaplain staffs appear to be on track, the line is not always involved. The Services need a formal method for sharing information about a service member's non-combat stress conditions before deployment for early identification and treatment. None of the Services had such a program.

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#### **Recommendation 4**

The Assistant Secretary of Defense (Health Affairs) should issue a Department of Defense policy document requiring that each Military Department develop a comprehensive combat stress control program that includes all the elements, prevention; identification; and treatment.

#### **Management Comments**

The ASD(HA) concurred with the recommendation. He indicated that the findings from our evaluation of combat stress control management in DoD suggest issuance of a policy

document, together with appropriate tri-Service followup, would help to focus needed additional emphasis on combat stress control.

The Army, Navy, Air Force, and the Joint Staff also agreed with the recommendation. The Air Force has taken corrective action to improve its combat stress control program. Those actions include maintenance of a mental health rapid response team and modularized teams, intended to provide early diagnosis and treatment of combat stress in early deployers, are expected to come on-line soon. Mental health expansion and augmentation modules are being developed that will add significant capability for the support of Air Force operations.

**Audit Response**

Comments from the ASD(HA) were responsive.

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## C. TRAINING

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Training is the third, and last, structural process that is critical to the success of a comprehensive combat stress control program. Training, like implementation, varied among the Services. Several individuals we interviewed described the stress associated with military training as acclimating individuals to handle combat stress, but we do not have comprehensive data to corroborate that assertion. While handling the stress generated by military training is important for the total development of the service member and may have some preventive value relating to combat stress, our focus is on comprehensive training for combat stress management. In this section we will provide an overview of the formal training the Services provided.

We will also discuss a few of the many courses that addressed the issue extremely well. If no course met the our general requirements, we identified subjects based on our research that we believe should be covered in a training program.

### COMBAT STRESS MANAGEMENT TRAINING

Each Service approached the training for combat stress management differently. The Army included training of some aspect of combat stress management at almost all rank categories. The other Services provided training only to those who were subjected to combat stress or who were in some way associated with combat stress casualties. Rank categories are groupings of grades of service members with similar levels of responsibility. For example, junior noncommissioned officers (NCO) are grades E4 through E6 and junior officers are O1 and O2.

#### Training Overview

In Figure 3-1, we provide a general overview of the formal combat stress training provided to service members based on their rank category. The training programs we selected were the basic ones offered to most of the service members at a specific rank category. Examples include the Senior Noncommissioned Officer Course for senior NCOs and the Army Command and General Staff College for majors. We evaluated only direct training and formal courses. We did not examine training and exercises provided at the base or unit level. We address chaplains and medical staff separately because they are deeply tied to the identification and treatment of combat stress casualties; and training for them is specialized.

### ***Formal Combat Stress Training Coverage Provided by the Services***

Rank Category	Army	Navy	Air Force	Marine Corps	Joint Service
Junior Enlisted (E1-E4*)	No	No	No	No	Does Not Apply
Junior NCO (E4*-E6)	Yes	No	No	Yes	Does Not Apply
Senior NCO (E7-E9)	Yes	No	No	Some	Does Not Apply
Basic Officer (O1-O2)	No Now, Future Yes	No	Generally - No Opt at Academy	Yes	Does Not Apply
Company Grade Officer (O3)	Yes Now, Future Some	Some	Yes	Yes	Does Not Apply
Field Grade Officer (O4-O5)	Yes	No	No	No	Does Not Apply
Senior Officer (O6)	Some - Elective	No	No	No	No
General or Flag Officer (O6-O10)	Does Not Apply	Does Not Apply	Yes (Joint Course)	Does Not Apply	Not in Capstone Course
Chaplains	Yes	Yes	Yes	Yes	Does Not Apply
Medical Staff	Yes	Some	Yes	Yes	Does Not Apply

\*E4 category varies depending on the Branch of Service.

Figure 3-1

#### **Weaknesses in Service Training Programs**

The Service training programs had several weaknesses. Because awareness and recognition of combat stress are important medical readiness issues to military personnel serving in units involved in combat or combat service support functions, some level of training in combat stress management is essential for most of those military personnel. The training provided is dependent on the branch of Service and the rank and level of responsibility of the service member. The wide disparity in the training among the Services shows possible voids in individual service member's training. In addition, the proposed change by the Army to remove most combat stress management training from the Advanced Officer Course for company grade officers will result in a deficiency in the training of key Army officers.

The junior NCO or the company grade officer will probably be one of the first individuals to encounter a combat stress casualty within his or her unit; therefore, detailed training in all the Services should be mandatory for those individuals. Senior NCOs and field grade officers may have to decide, independently or in conjunction with medical staff, whether the stress-related casualty should be treated within the unit or transferred to a higher echelon. Those individuals require training in the management of combat stress casualties. The medical staff and chaplains need to be trained in all levels of identification and treatment of combat stress casualties, because they will provide

the support and treatment for the more severe casualties. Finally, senior officers and general or flag officers should be made aware of combat stress as an operational issue. In turn, they, as leaders, play a key role in the general management and planning associated with combat stress.

## **SELECTED SUBJECTS AND COURSES**

Based on our general review of the formal training programs within the Services, we identified selected types of training that support our position for education concerning combat stress. The training relates to specific courses and describes other subjects that could be covered.

### **Enlisted Member Training**

The level of training that should be provided to enlisted members varies by rank category. Junior enlisted members require less detailed training than the junior and senior NCOs. The following describes examples of subjects for consideration at each level of enlisted member.

- Junior enlisted - Those individuals need a basic understanding of combat stress, stressors, and stress reactions. They need a discussion regarding the feelings they may experience and basic information on recognizing combat stress in others.
- Junior NCOs - Those individuals need more detailed instruction. They need an in-depth review of combat stress, stressors, and stress reactions; a general understanding of combat stress prevention; and an in-depth discussion of combat stress identification and treatment.

The Marine Corps offers a 2-hour class on combat stress as part of the corporals NCO programs. The purpose of the class is to provide an understanding of combat stress to assist the NCO in identifying signs of mild and serious combat stress.

- Senior NCOs - Senior NCOs need to concentrate on understanding the stressors that could induce combat stress in their subordinates during a combat situation. They also need to be educated in techniques for preventing those stressors and situations. Senior NCOs, as leaders, also play a critical role in the immediate treatment of combat stress casualties and, as such, need to be educated in basic treatment techniques.

### **Officer Training**

Officer training levels, specifically for combat stress management, also vary with the rank category of the service member. Company grade officers in combat and combat service support specialties require the most detailed training on the specifics of combat stress prevention, identification, and treatment. Senior officers require education concerning management and planning as follows.

- Officers in basic officer orientation and junior officers - Those individuals need a basic understanding of combat stress, stressors, and stress reactions. Additionally, they need an overview regarding prevention, identification, and treatment of combat stress in themselves and others in their units.

The Army plans to include a session in the Officer Basic Course that covers combat stress management. Subjects covered include defining combat stress, sources of stress, signs of stress, protection against battle fatigue, and treatment.

- Company grade officers - As the first line officers, those individuals need a detailed education in combat stress prevention, identification, and treatment techniques. Those individuals need to understand the psychological and physiological effects of combat stress.

A Navy training course, "Tactical Decision Making Under Stress," offered at the Surface Warfare Officer's School subjects officers to stress exposure training based on a simulated combat situation. That type of training is beneficial in that it provides hands-on experience in potentially stressful combat situations. Other Services may offer similar training.

- Field grade officers - Training for field grade officers should focus more on the prevention of combat stress. Those officers need to understand the stressors that could induce combat stress in their service members during a combat situation. They also need to be educated in the techniques that will support preventing those stressors, such as predeployment briefings, and understanding the personal stress that their unit members may be experiencing.
- Senior officers - Senior officers, having already received training in prevention, identification, and treatment of combat stress, need to be educated in the subject from a more strategic planning level. They need to exercise their skills for planning for combat stress casualties. Wargames help them understand the medical echelons and the roles of each player in those echelons.
- General or flag officers - Generals and admirals need to integrate combat stress into their strategic and operational perspectives on combat operations. The Capstone Course, the primary course for general and flag officers taught through the National Defense University, does not address combat stress. We suggested that the University evaluate offering a lecture, similar to the Air Force course, "Nature of War," offered in the Joint Flag Officer Warfighting Course. That lecture discusses the effects

### **Chaplain and Medical Staff Training**

that human factors have on performance and battlefield effectiveness and examines how leaders can influence human factors with regard to friendly and enemy battlefield performance and combat operations.

Medical officers, chaplains, and medical and chaplain support staff all need to be trained in combat stress, stressors, reactions, and treatment. The Services, except the Navy, do provide the training to those military specialists. The Navy provides only combat stress training to those medical staff members who have been assigned as direct medical support for the Marine Corps.

An example of the type of training that medical staff could receive is the combat stress presentation to Air Force officers as part of their Military Indoctrination For Medical Service program. That program addresses several key aspects of combat stress control, such as the history of combat stress; causes and contributing factors to stressors; signs and symptoms of combat stress; manifestation of stress reactions; prevention of combat stress; and the treatment of combat stress casualties. Another example is the Uniformed Services University of the Health Sciences course for future military medical officers, "Battle Fatigue Identification, Management, and Prevention."

Chaplain staff could receive training that addresses ministry in combat issues. The chaplain services are important because, as stated in Marine Corps Fleet Marine Force Manual 3-61, "Ministry in Combat," June 1992, they become the "bridge between the horrible realities of war and the peace of spiritual contentment." Examples of appropriate training include ministry in a readiness environment; caretaking in disasters; dynamics of critical incidents and associated stress; and ministry to casualties, including those with combat stress.

### **TRAINING SUMMARY**

We suggest each Service address combat stress as part of its total training program for each service member, depending on the branch, rank, and prospective responsibilities. That training can be through any training media, such as formal courses, exercises, videos, or transportable training programs.

Because we support combat stress education at varying rank categories, we do not agree with the change in Army training that removes combat stress control education from the Officer Advanced Course. Additionally, we suggest that the Navy add combat stress management to the training for all medical staff, not just those assigned to Marine Corps units. Finally, the National Defense University should evaluate adding combat stress management education to the Capstone Course.

**Recommendation 5**

Each Service should ensure that appropriate training in combat stress management is provided for service members. The content or the level of the training should be appropriate for the branch, rank, and level of responsibility of the service member. The Services should exchange information concerning combat stress control and explore the possibility of joint Service training.

**Management Comments**

The Army suggested that we expand our draft report recommendation to have representatives from each Service meet to jointly address issues of combat stress. It further explained that while the report contains some recommendations for training, efficiencies can be gained by exchanging information and exploring the possibility of joint Service training at the beginning level, with the Services providing training specific to their own requirements. We agree and suggest that the Army take the lead in arranging a meeting to kick off the joint effort that the Army proposed. If the ASD(HA) or Joint Staff would prefer to be the sponsor, we leave it to them and the Army to work out. The Navy concurred with the recommendation. The Air Force concurred with the findings and recommendations, particularly regarding training. The ASD(HA) and the Joint Staff also concurred with the recommendation.

**Audit Response**

The comments from the Army were responsive.

The Navy concurred with the recommendation but did not identify changes planned to incorporate combat stress control management into its training program. The comments from the Air Force were partially responsive. While the Air Force concurred with the recommendation, it does not have an adequate training program. The Air Force did not identify changes planned to improve its training program. As part of the IG, DoD, followup process later this year, we will ask the Services, especially the Navy and Air Force, to provide details on enhancements to their training efforts. By that time, we hope that the initiative to explore joint training will have paid off.

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## PART IV - MANAGEMENT COMMENTS

### DEPARTMENT OF THE ARMY COMMENTS



REPLY TO  
ATTENTION OF

DEPARTMENT OF THE ARMY  
OFFICE OF THE ASSISTANT SECRETARY  
MANPOWER AND RESERVE AFFAIRS  
111 ARMY PENTAGON  
WASHINGTON DC 20310-0111

November 30, 1995



MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL  
ATTN: MS. BRILLIANT

SUBJECT: Draft Report on Management of Combat Stress

Reference your memorandum dated September 29, 1995, subject as above.

Army concurs with your draft report with the following comment.

We suggest you recommend that representatives from each service meet jointly to address issues of combat stress control. While the draft report contains some recommendations for training, which we are vitally interested in, we think there are some efficiencies to be gained by exchanging information and exploring the possibility of a joint service training at the beginning level; with the Services providing training specific to their own requirements.

John P. McLaurin  
Deputy Assistant Secretary  
(Military Personnel Management and  
Equal Opportunity Policy)

Printed on Recycled Paper

## DEPARTMENT OF THE NAVY COMMENTS



DEPARTMENT OF THE NAVY  
OFFICE OF THE SECRETARY  
1000 NAVY PENTAGON  
WASHINGTON, D.C. 20350-1000

FEB 8 1996

MEMORANDUM FOR THE DEPARTMENT OF DEFENSE (INSPECTOR GENERAL)

SUBJECT: Draft Report on Management of Combat Stress Control in  
the Department of Defense - INFORMATION MEMORANDUM

Per Attached, Navy concurs with the draft report and its  
five recommendations.

The five recommendations are designed to ensure that a  
systematic management approach be implemented which addresses all  
facets of combat stress control: development of joint doctrine,  
functional responsibility for policy, development of programs,  
and training for service members.

*Karen S. Heath*

KAREN S. HEATH  
Assistant Secretary of the Navy  
(Manpower and Reserve Affairs)  
Acting

Attachment:  
DoDIG memo of 29 Sep 95 w/draft report

\*

\*Attachment Deleted

## DEPARTMENT OF THE AIR FORCE COMMENTS



SECRETARY OF THE AIR FORCE  
WASHINGTON

MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL, DEPARTMENT OF  
DEFENSE (AUDITING)

SUBJECT: Evaluation of the Management of Combat Stress Control in DoD (Your Draft  
Report, 29 Sep 95)

We concur with your findings and recommendations, particularly regarding training, and appreciate the opportunity to review this report.

The subject report finds the Air Force "not ready" to support the management of combat stress as "it does not have a combat stress control program." We appreciate the great significance of this form of disability to our combat forces and have already taken steps to obviate this finding.

The Air Force now maintains a Mental Health Rapid Response Team which was recently concept tested in Oklahoma City. More modularized teams are expected to come on line soon and are specifically intended to provide early diagnosis and treatment of Combat Stress in our early deployers. Air Mobility Command is leading efforts to develop Mental Health Expansion and Augmentation modules which will add significant capability for the support of Air Force operations during theatre build up.

Our point of contact for these issues is Col Karl O. Moe, HQ AFMOA/SGOC, 110 Luke Avenue, Room 400, Bolling AFB, DC 20332-7050, (202) 767-2591 or DSN 297-2591.

A handwritten signature in cursive script, reading "Sheila E. Widdall".

Sheila E. Widdall

## ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) COMMENTS



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

DEC 04 1995

### MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL FOR AUDITING

SUBJECT: Draft Report on Management of Combat Stress Control in the Department of Defense, September 29, 1995

Thank you for the opportunity to comment on the recommendations of the subject draft report. The report represents an excellent compilation of key information and cogent analysis on a very important topic.

**Recommendation 1.** The Assistant Secretary of Defense (Health Affairs), in coordination with the Joint Staff, the Defense Medical Standardization Board, the Military Departments, and the Defense Modeling and Simulation Office, should continue all activities necessary to implement action plans 4, 6, 7, and 8 outlined in the Medical Readiness Strategic Plan 2001, in order to incorporate fully combat stress casualty estimates into the medical planning programs used by the Unified Commanders and the Service Chiefs. In addition, the Assistant Secretary of Defense (Health Affairs) should ensure implementation plans have realistic milestones set and are adequately resourced.

**Comment.** Concur. My staff is actively engaged in oversight of the timely implementation and resourcing of the component action plans of Medical Readiness Strategic Plan 2001, which do contain an appropriate emphasis on combat stress control.

**Recommendation 2.** The Assistant Secretary of Defense (Health Affairs) should formally assume functional responsibility for policy, coordination and oversight of planning, implementation, and training related to combat stress control within the Department.

**Comment.** Concur with comment. The Department of Defense Medical Program Guidance specifies the overall functional responsibility of the Assistant Secretary of Defense (Health Affairs) for policy, coordination and oversight of the Defense Medical Program. Specific references to the key elements of combat health support are included in the Readiness Core Area section of the Program Guidance. My staff will add language to this section of the draft Defense Medical Program Guidance for Fiscal Years 1997 to 2001, now in preparation, to focus appropriate attention on combat stress control.

**Recommendation 3.** The Joint Staff, in coordination with the Assistant Secretary of Defense (Health Affairs) and the Military Departments, should incorporate combat stress management guidance into joint doctrine. The guidance should address combat stress prevention, identification, and treatment in joint operations; consider Service-unique requirements; and be included in a joint doctrine that addresses broader health care issues associated with joint operations.

**Comment.** Concur.

## ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) COMMENTS (Cont'd)

**Recommendation 4.** The Assistant Secretary of Defense (Health Affairs) should issue a Department of Defense policy document requiring that each Military Department develop a comprehensive combat stress control program that includes all the elements--prevention, identification, and treatment.

**Comment.** Concur. The draft report's findings suggest that issuance of the recommended policy document, together with appropriate tri-Service follow-up, would help to focus needed additional emphasis on combat stress control.

**Recommendation 5.** Each Service should ensure that appropriate training in combat stress management is provided for service members. The content or the level of the training should be appropriate for the branch, rank, and level of responsibility of the service member.

**Comment.** Concur.

I look forward to the release of the report in its final form. My point of contact is Colonel Michael A. Dunn, Director, Clinical Consultation, at DSN 225-6800.

*Edward D. Martin* /fo  
Stephen C. Joseph, M.D., M.P.H.

## DIRECTOR OF THE JOINT STAFF COMMENTS\*



INSPECTOR GENERAL  
DEPARTMENT OF DEFENSE  
400 ARMY NAVY DRIVE  
ARLINGTON, VIRGINIA 22202-2884



September 29, 1995

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS  
ASSISTANT SECRETARY OF DEFENSE  
(HEALTH AFFAIRS)  
DIRECTOR, JOINT STAFF

SUBJECT: Draft Report on Management of Combat Stress Control in the Department of Defense

We are providing this draft report on our evaluation of the management of combat stress control for your review and comment. Management is requested to provide comments indicating concurrence or nonconcurrence with the recommendations within 60 days.

We appreciate the courtesies extended to our evaluators. If you should need additional information, please contact Ms. Betsy Brilliant, Review Director, at (703) 604-8745.

Robert J. Lieberman  
Assistant Inspector General  
for Auditing

Enclosure

cc: Surgeons General of the Military Departments

Director, Joint Staff

\*Receipt acknowledged, no comments provided.

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## PART V - ADDITIONAL INFORMATION

### APPENDIX A - REFERENCES

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## APPENDIX B - ORGANIZATIONS VISITED OR CONTACTED

### OFFICE OF THE SECRETARY OF DEFENSE

Assistant Secretary of Defense (Health Affairs), Arlington, VA  
Uniformed Services University of the Health Sciences, Bethesda,  
MD

### JOINT STAFF AND OTHER JOINT ORGANIZATIONS

The Joint Staff, Directorate for Manpower and Personnel,  
Arlington, VA  
The Joint Staff, Directorate for Logistics, Arlington, VA  
National Defense University, Fort McNair, Washington, DC

### UNIFIED COMMAND

Surgeon General, United States Atlantic Command, Norfolk  
Naval Base, VA

### ARMY

Surgeon General, Commander, U.S. Army Medical Command,  
Falls Church, VA

Army Medical Department Center and School, Fort Sam  
Houston, TX

Walter Reed Army Institute of Research, Walter Reed Army  
Medical Center Forest Glen Annex, Silver Spring, MD

Womack Army Medical Center, Fort Bragg, NC

XVIII Airborne Corps, 528th Combat Stress Control  
Detachment, Fort Bragg, NC

Army Training and Doctrine Command, Fort Monroe, VA

Army War College, Carlisle Barracks, PA

Army Command and General Staff College, Fort Leavenworth,  
KS

Army Chaplain Center and School, Fort Monmouth, NJ

Army Sergeants Major Academy, Fort Bliss, TX

## APPENDIX B - ORGANIZATIONS VISITED OR CONTACTED (Cont'd)

### NAVY

Surgeon General, Chief, Bureau of Medicine and Surgery,  
Washington, DC

National Naval Medical Center, Bethesda, MD

Naval Aerospace and Operational Medical Institute, Pensacola  
Naval Air Station, FL

TRICARE Office, Walter Reed Army Medical Center,  
Washington, DC

Naval Doctrine Command, Norfolk Naval Base, Norfolk, VA

Naval Doctrine Command, Quantico, VA

Naval Education and Training Command, Pensacola Naval Air  
Station, FL

Naval Health Sciences Education and Training Command,  
Bethesda, MD

Naval Training Center, Great Lakes, IL

Newport Naval Education and Training Center, Newport, RI

Naval Air Warfare Center, Orlando, FL

Bureau of Naval Personnel, Arlington, VA

### AIR FORCE

Surgeon General, Bolling Air Force Base, DC

Deputy Chief of Staff, Personnel, Arlington, VA

Malcolm Grow Hospital, Andrews Air Force Base, MD

Wilford Hall Medical Center, San Antonio, TX

Air Education and Training Command,  
Lackland Air Force Base, TX

Air Education and Training Command,  
Maxwell Air Force Base, Alabama

## **APPENDIX B - ORGANIZATIONS VISITED OR CONTACTED (Cont'd)**

<b>MARINE CORPS</b>	Office of the Commandant of the Marine Corps, Deputy Chief of Staff, Manpower and Reserve Affairs, Clarendon, VA
	Marine Corps Medical Office, Henderson Hall, Arlington, VA
	Marine Corps Combat Development Command, Quantico, VA
	U.S. Marine Corps Forces Atlantic, Camp LeJeune, NC
	2nd Marine Division, Camp Lejeune, NC
	Naval Hospital, Camp LeJeune, NC
	Chaplain of the Marine Corps, Navy Annex, Arlington, VA
<b>CIVILIAN</b>	International Critical Incident Stress Foundation, Inc., Ellicott City, MD
	National Organization for Victim Assistance, Washington, DC
<b>INTERNATIONAL</b>	British Army Staff, British Embassy, Washington DC

## **APPENDIX C - REPORT DISTRIBUTION**

### **Office of the Secretary of Defense**

Under Secretary of Defense (Comptroller)  
Deputy Chief Financial Officer  
Deputy Comptroller (Program/Budget)  
Assistant Secretary of Defense (Health Affairs)  
Assistant to the Secretary of Defense (Public Affairs)  
Director, Defense Logistics Studies Information Exchange

### **Joint Staff**

Director for Manpower and Personnel  
Director for Logistics

### **Department of the Army**

Secretary of the Army  
Assistant Secretary of the Army (Financial Management and Comptroller)  
Assistant Secretary of the Army (Manpower and Reserve Affairs)  
Surgeon General of the Army  
Deputy Assistant Secretary (Military Personnel Management and Equal Opportunity Policy)  
Auditor General, Department of the Army

### **Department of the Navy**

Secretary of the Navy  
Assistant Secretary of the Navy (Financial Management and Comptroller)  
Assistant Secretary of the Navy (Manpower and Reserve Affairs)  
Surgeon General of the Navy  
Auditor General, Department of the Navy

### **Department of the Air Force**

Secretary of the Air Force  
Assistant Secretary of the Air Force (Financial Management and Comptroller)  
Assistant Secretary of the Air Force (Manpower, Reserve Affairs, Installations, and Environment)  
Surgeon General of the Air Force  
Auditor General, Department of the Air Force

### **Marine Corps**

Commandant, U.S. Marine Corps

## **APPENDIX C - REPORT DISTRIBUTION (Cont'd)**

### **Other Defense Organizations**

Director, Defense Contract Audit Agency  
Director, Defense Logistics Agency  
Director, National Security Agency  
Inspector General, National Security Agency

### **Non-Defense Federal Organizations and Individuals**

Office of Management and Budget  
General Accounting Office  
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This report was produced by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD.

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## INTERNET DOCUMENT INFORMATION FORM

**A . Report Title:** Evaluation Report on the Management of Combat Stress Control in the Department of Defense

**B. DATE Report Downloaded From the Internet:** 12/06/99

**C. Report's Point of Contact: (Name, Organization, Address, Office Symbol, & Ph #):** OAIG-AUD (ATTN: AFTS Audit Suggestions)  
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**D. Currently Applicable Classification Level:** Unclassified

**E. Distribution Statement A:** Approved for Public Release

**F. The foregoing information was compiled and provided by:**  
DTIC-OCA, Initials: \_\_VM\_\_ Preparation Date 12/06/99

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